and modern telecommunications could be introduced to provide audiovisual consultant advice. The provincial government would likely be forced to increase the provincial fee schedule, not only to attract physicians from other parts of Canada but also to retain Saskatchewan's own graduates.

I am certain that the people of Saskatchewan are grateful for the many very competent graduates of foreign medical schools who have provided for their medical needs over the years. I am also certain that the people of Saskatchewan would prefer that their medical needs be met by their own young people. It is sad that the home of Canadian medicare cannot find the financial means or the political will to educate its own sons and daughters in what I have found to be a very rewarding profession.

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What you should know about HSOs

It is ironic that the Feb. 15, 1988, issue of *CMAJ* (vol. 138) should contain the Special Report "What you should know about HSOs", by Drs. David Peachey and Adam Linton (pages 352 to 355) as well as a review by Jane Fulton, PhD, of Geoffrey York's book *The High Price of Health. A Patient's Guide to the Hazards of Medical Politics* (page 341).

My first reaction to the book review was to dismiss York's criticism of the profession — which was enthusiastically espoused by the reviewer — as another example of "doctor bashing". What is the evidence that the profession does not support reforms, including alternatives to fee-for-service, as York implies?

To my chagrin, the next article I turned to was written by Dr. Peachey, director of professional affairs of the Ontario Medical Association (OMA), and Dr. Linton, a member of the OMA Board of Directors. These authors have supplied a good deal of the evidence required by York to support his stand.

Peachey and Linton begin by stating that HSOs (health service organizations) are espoused by all three major political parties in Canada and that the impetus for the establishment of HSOs is largely fiscal and on government initiative. They urge doctors to take a careful look at the HSO system before contracting to enter it. They then list what presumably they perceive as advantages and disadvantages.

For 14 years I have practised within two HSOs, which I was one of the key individuals in establishing. The initiative was that of the doctors who subsequently practised in them, and our motivation was a realization that there might be a better way to remunerate primary care services than by piecework, as in the fee-for-service system. I could expand on that, as could any physician who practises in an HSO.

Almost none of the advantages that I have experienced are referred to by Peachey and Linton. On the other hand, they mention numerous potential disadvantages, a number of which seem to have little relation to funding, and others of which seem to imply a real ignorance of what actually takes place within an HSO.

Having read this biased report I felt some of the rage that must have inspired York to write his criticism of our profession.

The OMA position on HSOs, as listed in a sidebar within Peachey and Linton's article, states that "the OMA supports the development of alternate methods of health care delivery and alternate means of compensation for physicians". It also states that "the OMA has equal obligations to members who practise fee-for-service medicine and to members who are compensated by salary or capitation".

As a member of the OMA for the past 28 years and as one who has derived his professional income from capitation for 14 years, I do not sense that support. Nor is the information provided about HSOs by two officials of the OMA an indication of a dispassionate or even a fair view of an alternative method of care. A more balanced view of the advantages and disadvantages from some of us who know the system and who are engaged in primary care might dispel some of the impression that organized medicine is reactionary, self-serving and right-winged.

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I have read the article by Drs. Peachey and Linton and the sidebar by Sidney Katz (pages 355 to 357) and feel that a number of comments are justified.

Physicians working in a capitated HSO do not have a fixed income and are not on salary. Monthly capitation payments are received from the Ministry of Health, as are fee-for-service payments. And our incomes do fluctuate from month to month, depending not on the number and type of services provided, as in the fee-for-service system, but on the number of patients registered with the group; this number changes as families leave or are attracted to our practices. Financial success in the capitation system depends on patients' satisfaction with the services they receive.

Disadvantages for patients of capitated practices are certainly possible, as is pointed out. In reality, though, most of them do not exist. Our practices are not "impersonal clinic setups". Our patients have chosen their personal physician and relate to him or her on a one-to-one basis. Patients expect and appreciate care from nurse practitioners and social workers, whom they recognize as professionals with skills that their doctor does not have.

We do not use the emergency department as a referral point, and most patients who do use it do so on their own volition, despite the provision of a 24-hour

and weekend on-call system. As the authors point out, this causes a loss of our entire monthly capitation fee, a significant financial disincentive.

Confidentiality is an important issue in all types of medical practice and is no less so in a capitated group. Documents do not leave our personal offices any more than anywhere else, and our computerized roster and encounter information is certainly more protected from unauthorized access than a stack of completed OHIP cards.

Impartial evaluation of the capitation system has been elusive for many years. I suggest that "acceptability" of the fee-for-service system to the public and the profession hardly qualifies as an objective evaluation of its efficacy. Until now it has been difficult to vote with one's feet, since the fee-for-service system has been all that was available.

Considering that in the heavily doctor-populated Hamilton–Dundas–Burlington area of Ontario more than 60 000 individuals receive primary health care from capitated HSOs, one might wonder whether these claimed disadvantages are real or whether they represent a subjective and biased scepticism toward a different way of doing things.

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[Drs. Peachey and Linton reply:]

Dr. Moore has demonstrated an unfortunate but revealing reaction to a non-assault. His concerns are somewhat difficult to deal with since they are unfocused and at least in part based on misinterpretation of our article. He quotes but does not reject our reference to the political impetus behind HSOs, and he does not seem to oppose careful consideration before physicians change their method of remuneration. He claims that we have omitted significant advantages that he has enjoyed, but he does not identify them. He objects to our list of potential disadvantages but does not provide a rational rebuttal of these.

We can only reply that many members and staff of the OMA have worked very hard to allow us to participate effectively in the debate on alternative methods of compensation and that this work has resulted in the sensible policies adopted by both the OMA and the CMA. These policies support the right of physicians to choose a method of compensation for professional services and advocate scientific evaluation of the effects of compensation systems. These are surely unexceptionable statements and do not seem to justify Moore's chagrin.

Moore missed an important punctuation mark. He quoted with disbelief from the OMA position paper on HSOs that "the OMA supports the development of alternate methods of health care delivery and alternate means of compensation for physicians". There is a comma after "physicians", such that the sentence can continue as follows: "provided that there is careful scientific assessment of the quality, cost efficiency, and effects of their operation".

In contrast, Dr. Mills provides for us an example of an established HSO in which many of the potential risks of this form of practice have been avoided, although, as he points out, the fiscal benefits of HSOs remain to be evaluated. Our report was not written without extensive reading and consultation with physicians using many methods of compensation, and we have seen HSOs in which Mills' success has certainly not been duplicated; we would be happy to present to Mills evidence that his local perception may be subject to as much bias as he attributes to us.

Mills is entirely correct that an impartial evaluation of the capitation system has been elusive. The OMA has pursued such a study with government repeatedly and will continue to do so.

Criticism of the OMA proposal on HSOs, presented at the CMA annual meeting last year, came exclusively from members blindly opposed to capitation payment, so we may derive some comfort from reaction from the other side of the fence.

The complexity and breadth of the issues that face physicians are addressed in the most effective manner when organized medicine is united. It would be tragic if we were divided by a chosen method of compensation. Support for our discussion paper from physicians compensated by fee-for-service and by capitation suggests that we are proceeding in the correct direction. Some HSO physicians have indicated that they would like to form a section on HSOs and work within the OMA. We would welcome this development as a positive step in the pursuit of a unified and strong profession.

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Influenza vaccination for athletes?

In temperate climates influenza generally occurs in the winter and early spring. The incubation period is short, 1 to 3 days. The virus is transmitted from person to person by the respiratory route, and closeness of personal contact indoors is a contributor to epidemic spread.

Influenza vaccination is a potentially valuable preventive measure for persons at high risk of serious illness or death during influenza outbreaks.[1] The relative efficacy of inactivated influenza vaccines is a subject of debate. Clearly, however, properly formulated vaccines can provide good protection against influenza.[2] Side effects of vaccination are generally mild and occur most frequently in children. Since 1976 an association between Guillain–Barré syndrome and influenza vaccination has not been verified.[1]